Graduate Journal of Counseling Psychology

Volume 1
Issue 2 *Spring 2009*

Article 7

3-1-2009

Dependent Personality Disorder: A Review of Etiology and Treatment

Chasidy Faith

Dependent Personality Disorder: A Review of Etiology and Treatment

Chasidy Faith

Abstract: Dependent personality disorder (DPD) is one of the most common personality disorders seen in mental health clinics. Those with DPD tend to cling to others and have an extreme need to be taken care of. Many of the diagnostic issues involve the comorbidity of DPD, especially with avoidant personality disorder. There are a wide range of theories that attempt to explain the etiology and treatment of DPD including: biological, environmental, social learning, and cognitive perspectives. Future research in process and outcome would benefit DPD, along with information about the comorbidity and cultural views for DPD. This paper will briefly examine the diagnostic concerns, ideas about etiology and treatment, and some of the historical and contextual issues related to DPD.

We have all been completely dependent on another person during our lifetime, although for many of us this only occurred during our younger years. Bornstein (1992) makes an important statement, "A few life experiences are so widely shared by people of different backgrounds that they transcend the boundaries of culture, gender, and ethnicity" (p. 3). Dependency is one of these experiences. Even when we have grown-up, we still show some degree of dependency on others and have a need for support, guidance, and approval from others, especially during stressful times (Bornstein, 1996). Dependency becomes a form of psychopathology when there is abnormal dependency and it causes personal distress and/or functional impairment (Sperry, 2003).

Personality disorders are enduring patterns in our behaviors and with dependent personality disorder (DPD) this pattern involves submissive, clinging behavior in which a person has an extreme need to be taken care of (American Psychiatric Association [APA], 2000; Perry, 2005). This pattern begins by early adulthood. These individuals may down play their assets and refer to themselves as stupid (APA, 2000). Sperry (2003) comments there is generally a lack of self-confidence, great discomfort in being alone, self-doubting, and approval seeking found with DPD. People with DPD may easily be taken advantage of because they are so compliant, agreeable, and trusting of others (Ansell & Grilo, 2007; Sperry, 2003).

DPD is part of the Cluster C personality disorders, along with avoidant and obsessive-compulsive personality disorders, which are all considered the anxious and fearful type (APA, 2000; Seligman & Reichenberg, 2007). Being among the most commonly diagnosed personality disorder, DPD is found in about 14% of people who have personality disorders and about 2.5% of the general population (Seligman & Reichenberg, 2007; Sperry, 2003). Other estimates have shown a median prevalence rate of 20%, with

a range from 2% to 55% (Fossati, et al., 2006). Although Cluster C personality disorders, including DPD, show high base rates they still have been studied less than other personality disorders (Endler & Kocovski, 2002; Fossati, et al., 2006; Gude, Hoffart, Hedley, & Ro, 2004).

In order to diagnose a person with DPD, they must exhibit five or more of the eight criteria that are listed in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition Text Revision (DSM-IV-TR, APA, 2000). These criteria include the ideas and concepts to follow. First, making simple everyday decisions is a great challenge, especially when others are not giving advice or reassurance. Second, a person with DPD wants others to be responsible for decisions involving the major areas in his or her life such as what career to follow, where to live, or possibly even when to have children. According to Sperry (2003) this is the optimal criterion, meaning using this criterion in diagnosing DPD has been shown to be the most useful. Third, they may say they agree with others when in reality they do not. The agreement is preferred because of a fear they will otherwise lose peoples' support. Fourth, due to a great lack in self-confidence it becomes very difficult to begin projects on their own. The fifth criterion states that a person will go to extreme lengths and endure unpleasant events. These events could be minor, such as going to a restaurant they do not particularly care for, or severe such as tolerating physical and/or sexual abuse (APA, 2000). Sixth, many times being alone is just simply not an option and is very uncomfortable. Therefore, the seventh criterion says that when one relationship comes to end another quickly begins. People with DPD believe they cannot function on their own. Finally, the eighth criterion notes that because of a belief that they are dependent on others' advice and help there is a fear of abandonment which will mean they will have to care for themselves.

Diagnostic issues have been noted, especially involving the comorbidity of DPD. For example, 43% of the people diagnosed with avoidant personality disorder (APD) also met the criteria for DPD; 59% of patients with DPD met criteria for APD (Fossati, et al., 2006). This leaves one to question if these two criteria sets are distinguishable from one another. Fossati et al. (2006) made an important finding regarding criteria 1 thru 5 for DPD and criterion 4 with APD diagnoses. These criteria, "…were not efficient indicators of the respective latent variables" (p. 200). This raises a big issue with DPD because 62.5% of the diagnostic identifiers are involved in criteria 1 thru 5. An example is given comparing criterion 3 for DPD, difficulty expressing disagreement, and criterion 4 for APD, excessive fear of being criticized. The criterion for DPD may be related to either a great need for dependency or to this fear of being

criticized. Therefore, Fossati et al. (2006) argue that the convergent and within-cluster discriminant validity needs further consideration.

DPD has also been shown to be comorbid with mood and anxiety disorders, such as depression, phobias, obsessive-compulsive, and alcohol abuse (APA, 2000; Bornstein, 1992; Ng & Bornstein, 2005). Ansell and Grilo (2007) state that patients have poorer outcomes when they have the combination of mood and/or anxiety disorder along with dependency traits. Since DPD is so often co-occurring with other disorders, it is important to understand what effects comorbidity has on individuals. Yet, there is little known about how comorbidity affects DPD or the treatments that may be more useful for these individuals.

Etiology

Many ideas have been developed about the etiology of DPD. Early studies of dependent personality traits were looked at psychoanalytically (Bornstein, 1992, 1996). These traits were associated with breastfeeding and weaning. Those who became fixated at the oral stage would remain dependent on others for support. It was thought that high levels of dependency came from either frustration or overgratification during the oral stage, although research in this area has shown inconclusive results (Bornstein, 1996).

Studies have determined two parenting styles that lead to high levels of dependency in children (Bornstein, 1996). First, authoritarian parenting may create dependency. This is partly because this style of parenting prevents children from learning through trial-and-error, which is one way children develop autonomy and feelings of self-efficacy. Secondly, overprotective parenting can lead to high levels of dependency. Similar to authoritarian parenting, overprotective parenting makes children believe they cannot function on their own without the help, guidance, and support of others. It is important to note that studies have also shown dependent behaviors in children may encourage and reinforce parents' overprotectiveness and increase their demandingness (Bornstein, 1992).

In response to these early experiences within the family, cognitive structures are formed (Bornstein, 1992, 1996; Sperry, 2003). Children may develop beliefs and mental representations about their own self-efficacy and the power of others. Perry (2005) noted that a cognitive conceptualization has been created by some people who suggest these individuals first believe they are inadequate and helpless, followed by thinking that the best strategy to fix this is to find someone who may be able to deal with the world and protect them. Therefore, these children may be developing mental representations of themselves being helpless, inadequate, and failing on their own. This then leads them to seek out

other people to depend on in order to survive. Eskedal and Demetri (2006) discuss information on biological issues that may influence the development of DPD. Infants who have fearful, withdrawing, or sad temperaments and those with prolonged health issues during childhood may force parents to become overprotective, which in turn may lead to DPD. Interestingly, endomorphic and ectomorphic body types, which are common for dependent people, may also create more concern from parents (Eskedal & Demetri, 2006). These body types have low energy thresholds, which may create concern in parents.

Another view on the etiology of DPD is from social learning, simply stating people learn to be dependent (Bornstein, 1992). Initially it was believed that dependency was an acquired drive, although the importance of social reinforcement then became evident. People develop DPD because their dependency was or still is rewarded. One of the issues involved in this view is that children are experiencing conflict because they are taught to obey authority figures and to depend on these people for guidance and protection, yet they are also being taught to be creative and autonomous (Bornstein, 1992).

Historical and Contextual Issues Related to DPD

While there does not seem to be much research on culture and DPD, it is noted that consideration needs to be made regarding one's culture (APA, 2000; Perry, 2005). The diagnostic criteria need to be considered in light of the person's cultural norms because some cultures value characteristics such as passivity. Similarly, diagnosing DPD needs to be used with great caution, and perhaps not at all, with children and adolescents. It is essential to distinguish dependent behaviors that are developmentally appropriate from those that are not (APA, 2000).

More research and time has been spent looking at the differences that genders exhibit with DPD. Usually, DPD has been found to be more prevalent in females, although how much more prevalent is still up for debate (Bornstein, 1992; Eskedal & Demetri, 2006; Fossati, et al., 2006; Klonsky, Jane, Turkheimer, & Oltmanns, 2002; Loranger, 1996; Perry, 2005). Fascinatingly, when using projective measures of dependency, versus self-report, the typical finding is that men and women show similar levels of dependency (Bornstein, 1992; Eskedal & Demetri, 2006).

Bornstein (1992) has postulated a theory about why males and females may show similar findings when the test is projective and not a self-report. In general, self-report measures of dependency will ask direct questions about dependent traits, feelings, and behaviors. Males will be less likely than females to recognize and admit these dependent traits. When using

projective measures, the client is asked to respond to ambiguous stimuli, often being asked to provide open-ended descriptions. The client is unaware of what is exactly being looked for, so they will not distort their responses on the basis of what is socially desirable (Bornstein, 1992).

Another captivating trend regarding gender and prevalence rates is that longitudinal studies show little if any difference during early childhood in boys and girls dependency levels, however there is an increase in dependency differences as a child's age increases (Bornstein, 1992). This change in the prevalence of dependency may be accounted for by the traditional sex role that socialization practices. In general, boys are discouraged from expressing their feelings and needs of dependency, but girls are usually encouraged to do so (Bornstein, 1992). Role models, such as parents, teachers, siblings, etc. encourage this behavior even through subtle messages. The extent that men and women play out these socialized sex roles may also determine if they will develop psychopathic dependency. It has been shown that married women who follow the traditional sex role receive significantly higher scores on the dependency scale (Dy) for the Minnesota Multiphasic Personality Inventory (MMPI) versus women reporting that they live a reversal of the traditional sex roles in their marriage (Bornstein, 1992). In addition, Klonsky et al. (2002) found that higher femininity and lower masculinity were both associated with dependent traits, regardless of one's actual gender.

Treatment of DPD

When working with DPD it is important to keep in mind a few things throughout the treatment planning and intervention processes. First, these clients depend on others and therefore may view their therapist as another person to rely on (Seligman & Reichenberg, 2007). This reliance may initially be seen in their lack of communication if the therapist does not direct or ask the client what to discuss (Sperry, 2003). They may work very hard to please the therapist, which can be used to develop rapport and encourage an increased independence. Also, to develop rapport it is important to demonstrate a lot of support and acceptance. It may be helpful to begin in a directive and structured manner in order to give sessions a focus. Seligman and Reichenberg (2007) note the overall goal is to promote a clients' self-reliance, self-expression, and autonomy in the safety of counseling and to then transfer these characteristics outside of the sessions. Terminations may be difficult and caution needs to be taken so the client does not feel abandoned. Therapists must be aware that clients with DPD, more than any other client, are more apt to develop a

romantic attachment to the therapist (Seligman & Reichenberg, 2007). Therefore, setting clear boundaries are of the utmost importance.

There are a variety of treatment approaches for DPD, although there is concern because few, if any, controlled treatment outcome studies have been completed (Sperry, 2003). Much of the treatment literature contains case descriptions, uncontrolled studies, and some controlled trials that contain a mixture of personality disorders (Perry, 2005). Keeping the lack of research in mind, psychodynamic is one approach that may be used. Psychodynamic therapy attempts to help clients better cope with object losses and/or previous separations (Eskedal & Demetri, 2006; Sperry, 2003). Transference is thus important and the client is allowed to see the therapist as this lost object or relationship. When a good therapeutic relationship has been developed, the transference is recognized and provides insight into the client's problems while helping resolve the client's therapeutic issues (Eskedal & Demetri, 2006; Perry, 2005; Sperry, 2003).

Time-limited psychodynamic therapy has been said to be the treatment of choice for clients with DPD (Eskedal & Demetri, 2006; Sperry, 2003). Long-term psychodynamic therapy will allow a greater transference to occur which can be used to promote emotional growth, although this can take three or more years (Sperry, 2003). Today, this amount of time is not likely to be spent in therapy for a variety of reasons. Clients who have limited ego strength or a great degree of separation anxiety may not benefit from either short or long term psychodynamic therapy as much as they would from something else, such as a supportive treatment approach (Eskedal & Demetri, 2006). One last thing to note with psychodynamic therapy is the possibility of countertransference toward the client, often of contempt or disdain because of the dependency the client has on the counselor (Eskedal & Demetri, 2006).

Cognitive-behavioral therapy (CBT) is also used for DPD, with the goal of increasing a person's autonomy and self-efficacy (Sperry, 2003). Allowing some dependence initially is important so the client becomes engaged. As this relationship is formed, the therapist may challenge dichotomous beliefs, such as the need to either be dependent or independent with no in-between. Therapists should note what triggers a client. For example, situations in which a client faces being alone may trigger the client's maladaptive patterns, which then causes anxiety (Eskedal & Demetri, 2006; Perry, 2005). Knowing these triggers will allow the client to learn more adaptive ways to deal with difficult situations. The behavioral techniques used involve techniques such as assertiveness training or dating skills, homework, relaxation training, and role playing (Perry, 2005; Sperry, 2003).

Group psychotherapy has also been demonstrated to be successful in treating DPD (Sperry, 2003). However, group therapy is not advised for those with severe impairment or a lack of prosocial behavior. In addition, it should be determined if the client should be placed in a group that only targets dependency issues, or a group with mixed personality disorders (Sperry, 2003). Caution should be used so the client does not become lost in mixed groups. Furthermore, it should be noted that DPD homogeneous groups establish cohesion more quickly, offer instantaneous support, and may provide relief of symptoms at a greater pace (Eskedal & Demetri, 2006). A group setting will allow clients to try out adaptive behaviors while still being in a supportive setting (Eskedal & Demetri, 2006).

Although it may make sense that marital and family therapy may be very helpful, because DPD involves being dependent on someone, professional literature on these interventions is basically nonexistent (Sperry, 2003). Perry (2005) states that there are no studies that examine using only family therapy for DPD. When the dependency involves a family member or members, it may be helpful to include them to facilitate the client's progress outside of counseling. Doing so may reduce the amount of time it takes to help the client and also give support to the family members (Perry, 2005; Sperry, 2003). The therapist needs to identify what in the family or relationship is encouraging the dependency and help the family develop workable goals (Perry, 2005).

Day and residential therapies are used with clients who require a high level of support and treatment intensity (Perry, 2005). These patients often have other co-occurring Axis I and Axis II disorders. The therapy used with these particular individuals generally includes a mixture of individual and group therapy, and possibly other services such as occupational or expressive therapies (Perry, 2005). The duration for day treatment programs may range from 18 weeks to a year or more, while residential programs are more long term and for those who have not improved or have deteriorated with outpatient therapy or while living on their own (Perry, 2005). Day and residential therapies are said to be helpful, but there are not a great number of studies noted to support this statement.

Medications may be used in combination with therapies, although there are cautions in doing this. Often people diagnosed with DPD also have Axis I diagnoses, such as depression and anxiety, which may benefit from medication (Sperry, 2003). If a client is not diagnosed with an Axis I disorder along with DPD, medication should probably not be used because it may be abused (Eskedal & Demetri, 2006; Sperry, 2003). Interestingly enough, because of dependent client's help-seeking behaviors, physicians will often prescribe medications because of the

client's persistent complaints (Eskedal & Demetri, 2006). To support this idea, Eskedal and Demetri (2006) note one study found that DPD patients in a hospital setting received nearly 50% more medications as compared to nondependent patients with similar Axis I diagnoses, possibly due to this help-seeking behavior.

With all of these treatments listed, there still seems to be a need for studies on the effectiveness of each. There is some support for most of the treatments, but the lack of research on effective treatments has been surprising. During this review, there were not any studies found examining what exactly makes therapy work, for example the mediators and moderators of therapy. Dependency itself and the etiology of dependency seem to have a large amount of literature, including perspectives of different theories. However, DPD would benefit from more empirical support for treatments, with a focus on process and outcome research. With that being said, the prognosis for DPD seems to be relatively good (Perry, 2005; Seligman & Reichenberg, 2007; Sperry, 2003). Some reasons for this prognosis include: clients with DPD can form relationships and make commitments, they can ask for help, and they are trusting (Seligman & Reichenberg, 2007). This good prognosis may take a significant amount of time, such as months or years, but it can be reached (Perry, 2005).

During treatment there may be some great obstacles to overcome, which may affect the amount of time therapy will take. One of these obstacles involves the client experiencing a significant loss or separation in their personal support (Perry, 2005). With the need to depend on others, suddenly not having this other person available may overwhelm the client and result in a regression in therapy for the skills that have been learned. Perry (2005) notes that it is important for the therapist in this situation to be supportive, offering some suggestions and direction, while at the same time accepting the interruption or delay in the client's growth.

Perry (2005) discusses five other challenges that may often arise in treating a client diagnosed with DPD. First, as is characteristic of DPD, a client who begins therapy may make many requests for advice and help that the therapist is unable to give. Second, clients may place the therapist in a role of the dominant person who should take responsibility for decisions and tell the client how to run his or her life. The third challenge entails the client not making changes outside of therapy in order to keep the emotional attachment with the therapist. Fourth, it may be difficult when a client has punitive and unsatisfying relationships. Hearing repeated stories about mistreatment may make a therapist have a desire to either control the client's self-defeating pattern or punish them, perhaps unknowingly, for not changing. The client may then feel torn between

pleasing the therapist and being punished by his or her partner in the relationship outside of counseling. Finally, there are clients who avoid dealing with their separation issues in therapy. This may lead to difficulties during termination if the therapist does not address this avoidance. All of these issues can produce great obstacles in treatment.

Conclusion

In summary, DPD is a common issue seen in therapy. It is important to be knowledgeable about its etiology and treatment options in order to better serve clients. With the great range of ideas about the etiology and treatment of DPD, along with the lack of research available, there continues to be many unanswered questions. Studies that are better designed and more controlled would benefit the DPD literature, because there is a current lack of evidence-based treatments for this disorder. Fortunately, there seems to be a good prognosis for individuals diagnosed with DPD. Part of this may be because these clients are generally easier to develop a rapport with since they lean on others for support. Therapists can use this to their advantage, as long as they keep clear boundaries and help clients become more independent with time.

REFERENCES

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders-text revision* (4th ed.). Washington, DC: American Psychiatric Association.

Ansell, E. B. & Grilo, C. M. (2002). Personality disorders. In M. Hersen, S. M. Turner, D. C. Beidel (Eds.), *Adult psychopathology and diagnosis* (5th ed., pp. 633-678). Hoboken, NJ: John Wiley & Sons, Inc.

Bornstein, R. F. (1992). The dependent personality: Developmental, social, and clinical perspectives. Psychological Bulletin, *112*, 3-23.

Bornstein, R. F. (1996). Dependency. In C. G. Costello (Ed.), *Personality Characteristics of the Personality Disordered* (pp. 120-145). New York: John Wiley & Sons, Inc.

Endler, N. S., & Kocovski, N. L. (2002). Personality disorders at the crossroads. *Journal of Personality Disorders*, *16*, 487-502.

Eskedal, G. A., & Demetri, J. M. (2006). Etiology and treatment of cluster C personality disorders. *Journal of Mental Health Counseling*, *28*, 1-18.

Fossati, A., Beauchaine, T. P., Grazioli, F., Borroni, S., Carretta, I., De Vecchi, C., Cortinovis, F., Danelli, E., & Maffei, C. (2006).

Confirmatory factor analyses of DSM-IV cluster C personality disorder criteria. *Journal of Personality Disorders*, *20,* 186-203.

Gude, T., Hoffart, A., Hedley, L., & Ro, O. (2004). The dimensionality of dependent personality disorder. *Journal of Personality Disorders*, *18*, 604-610.

Klonsky, E. D., Jane, J. S., Turkheimer, E. & Oltmanns, T. F. (2002). Gender role and personality disorders. *Journal of Personality Disorders*, *16,* 464-476.

Loranger, A. W. (1996). Dependent personality disorder: Age, sex, and axis-I comorbidity. *The Journal of Nervous and Mental Disease*, *184*, 17-21.

Ng, H. M., & Bornstein, R. F. (2005). Comorbidity of dependent personality disorder and anxiety disorders: A meta-analytic review. *Clinical Psychology: Science and Practice*, *12*, 395-406.

Perry, J. C. (2005). Dependent personality disorder. In G. O. Gabbard, J. S. Beck, & J. Holmes (Eds.), *Oxford Textbook of Psychotherapy* (pp. 321-328). Oxford, NY: Oxford University Press Inc.

Seligman, L., & Reichenberg, L. W. (2007). Personality disorders. In *selecting effective treatments: A comprehensive, systematic guide to treating mental disorders* (3rd ed., pp. 419-485). San Francisco: Jossey-Bass.

Sperry, L. (2003). *Handbook of diagnosis and treatment of DSM-IV-TR personality disorders* (2nd ed.). New York: Brunner-Routledge.

Chasidy Faith
Chasidy Faith received her BA from the University of Wisconsin-Stevens Point, double majoring in Psychology and Spanish. She is currently working on her MA degree in counseling at Marquette University. She plans to continue her education to pursue a PhD in order to be a practicing psychologist and teach at the university level.